SAMPLE

Written Approval
for
Administration of Medication Training

_____

Name of Student

_____

Address of Student

_____

Phone Number of Student

This student has successfully mastered and demonstrated the required training(s) below:

☐ Oral, Topical, Inhalant Medication – valid for three (3) years Expiration Date: _____

☐ Injectable medication by a premeasured commercially prepared syringe – valid for one (1) year Expiration Date: _____

Trainer Information:

_____

Full name of Physician (MD/DO);
Pharmacist (R.Ph.), Physician Assistant (PA);
Advanced Practice Registered Nurse (APRN) or
Registered Nurse (RN)

_____

Signature / Title

_____

License Number

_____

_____

Address

(_____)_____

Phone Number

_____

Location of Training

_____

_____

Address of Training

_____

Date of Training